

FINANCIAL STATUS REPORT

(Short Form)

(Follow instructions on the back)



1. Federal Agency and Organizational Element to Which Report is Submitted Federal Co-Chair of Denali Commission	2. Federal Grant or Other Identifying Number Assigned By Federal Agency A-2004-10 Health Facilities Technical Assistance	OMB Approval No. 6348-0039	Page of 1 1 pages
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3. Recipient Organization (Name and complete address, including ZIP code) STATE OF ALASKA, DEPARTMENT OF HEALTH & SOCIAL SERVICES P.O. BOX 110650 JUNEAU, AK 99811

4. Employer Identification Number 1926001185A7	5. Recipient Account Number or Identifying Number 24319	6. Final Report <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	7. Basis <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accrual
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8. Funding/Grant Period (See Instructions) From: (Month, Day, Year) 08/01/04	To: (Month, Day, Year) 09/30/06	9. Period Covered by this Report From: (Month, Day, Year) 07/01/06	To: (Month, Day, Year) 09/30/06
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10. Transactions	I Previously Reported	II This Period	III Cumulative
a. Total outlays	2,206.66	416.97	2,623.63
b. Recipient share of outlays	0	0	0
c. Federal share of outlays	2,206.66	416.97	2,623.63
d. Total unliquidated obligations			8,000
e. Recipient share of unliquidated obligations			0
f. Federal share of unliquidated obligations			8,000
g. Total Federal share (Sum of lines c and f)			10,623.63
h. Total Federal funds authorized for this funding period			125,000
i. Unobligated balance of Federal funds (Line h minus line g)			114,376.37

11. Indirect Expense	a. Type of Rate (Place "X" in appropriate box)			
	<input checked="" type="checkbox"/> Provisional	<input type="checkbox"/> Predetermined	<input type="checkbox"/> Final	<input type="checkbox"/> Fixed
	b. Rate N/A	c. Base	d. Total Amount	e. Federal Share

12. Remarks: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation.
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13. Certification: I certify to the best of my knowledge and belief that this report is correct and complete and that all outlays and unliquidated obligations are for the purposes set forth in the award documents.

Typed or Printed Name and Title Patricia A. Carr, Health Program Manager, Division of Public Health	Telephone (Area code, number and extension) (907) 465-8618
Signature of Authorized Certifying Official <i>Patricia A. Carr</i>	Date Report Submitted 10/13/06

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ACCEPTED